



## Application for Conversion of Group Term Life Insurance

Aetna Life Insurance Company

*Application and payment of the first premium must be made within the time limit shown in your certificate or policy.*

### BRIEF DESCRIPTION OF CONVERSION PRIVILEGE

Subject to the terms of the Group Policy (as described in your group insurance certificate): (1) you may apply for an individual insurance policy in conversion of your Group Term Life Insurance and (2) the individual policy may be for the same amount which you are losing by termination of your insurance under the Group Policy, or for a lesser amount, depending upon the circumstances of the termination. Amounts previously received by you under the Group Policy are not eligible for conversion.

***No medical examination is required, but application and payment of the first premium must be made within 31 days of the date your Group Term Life Insurance terminates. Note that the converted policy may have different terms and conditions than the Group Term Life Insurance plan. It may contain exclusions, or exclusions different from those in the group policy.***

Premiums may be paid: annually, semi-annually, or quarterly by direct bill; or monthly by Aetna's Automatic Check Plan (ACP). Premiums may be paid other than annually only if the periodic premium is at least \$15.

### NOTICE OF ELIGIBILITY STATEMENT (TO BE COMPLETED BY THE EMPLOYER)

1. Name of Employer ..... State of Nebraska
2. Group Policy (Control) Number or Employee Policy Number ..... 473449
3. Suffix and Account Number (example 12-345) .....
4. Name of Employee .....
5. Employee Social Security Number .....
6. a. Date coverage began (fill in date): Basic Life ..... Supp Life .....
- b. If insured for Supplemental Life insurance, date of last increase, (fill in date or if not applicable, write N/A) .....
7. a. Date employment or eligibility terminated .....
- b. If totally disabled at this time, please state specific cause .....
- c. Last day worked if other than date in 7(a) .....
8. a. Date Life insurance canceled (Do not include 31 day extended coverage period.) .....
- b. Reason for cancellation of coverage .....
9. a. Amount of insurance canceled: Basic Life ..... Supp Life ..... Total .....
- b. Amount of Life Insurance remaining in force (when insurance is reduced due to an age or retirement reduction rule or due to payment of an Accelerated Death Benefit) .....
10. a. Date written notice of conversion right given to Employee (required in most states, strongly encouraged in others) .....
- b. If notice not furnished, show "None Given" and Why .....
11. Complete for Dependent Conversion
- a. Name of Dependent .....
- b. Amount of Dependent Insurance canceled: Life .....
12. Employee Home Telephone Number .....

Signature (Employer Authorized Representative)		Date
Address	E-mail Address	Telephone Number

### WHERE TO SEND YOUR APPLICATION

You should send your application and check or money order for the initial premium to: Aetna Life Insurance Company  
P.O. Box 24846  
Cleveland, OH 44124-0846

NOTE: Be sure the above NOTICE OF ELIGIBILITY STATEMENT has been completed by the employer.

NOTE: This folder shows premium rates for a non-participating permanent type life insurance plan. It is offered in accordance with the conversion privilege contained in the group policy. The premiums for this plan do not vary based on the sex of the applicant.

NOTE: The signature of the Proposed Insured (the person requesting to be insured) is required otherwise, the form will be returned.

NOTE: If other than the Proposed Insured is to be the Policy Owner, the person who will be the Policy Owner should sign the application as Applicant. (Where this occurs, use Section 7 "Additional Information" to designate a contingent Policy Owner.)



# Application for Conversion of Group Term Life Insurance

Aetna Life Insurance Company, Cleveland, Ohio 44124-0846

I hereby apply for a policy of insurance upon my life in accordance with the provisions of Group Policy Number \_\_\_\_\_  
insuring my life as an employee of \_\_\_\_\_

1. Proposed Insured (Print Name - First, Initial, Last)*		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)	Telephone Number
2. Residence (Number, Street, City, County, State, ZIP Code)		Social Security Number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]		
3. Occupation when employment terminated. Full Details.				
4. a. Plan Whole Life Insurance		b. Amount of Insurance: (Must not exceed amount of term insurance in effect less any previously paid Accelerated Death Benefit, when employment terminated.) Basic and/or Supp Life \$ _____		
c. Premium Payable *Complete Deduction Form <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> ACP/Monthly*		d. Make Automatic Premium Loan Provision operative, if available. <input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Premium Notices to be sent <input type="checkbox"/> Insured at Residence <input type="checkbox"/> Other _____				
6. a. Beneficiary (NAME AND RELATIONSHIP TO PROPOSED INSURED) (NAME AND RELATIONSHIP TO PROPOSED INSURED) Primary _____ Contingent _____ Unless otherwise requested herein, payment is to be made: to primary beneficiaries who survive the Insured, equally, or if none survives; to contingent beneficiaries who survive, equally, or if none survives; to Insured's estate.				
b. Policy Owner (Unless otherwise requested, Proposed Insured is to be Policy Owner.)				
7. Additional Information (Refer to specific question number.)				

**IT IS MUTUALLY AGREED THAT:** The statements and answers made herein are complete and true to the best of my knowledge and belief. Issuance of the policy applied for shall be exchanged for all privileges and benefits with respect to the full amount of term insurance (minus any age or retirement reduction rule or Accelerated Death Benefit) on my life under the Group Policy. I understand that the converted policy may have different terms and conditions than the Group Policy. No person other than an officer of Aetna can make, modify, or discharge a contract or waive any of Aetna's rights or requirements.

Signed at \_\_\_\_\_ (City, State) on \_\_\_\_\_ (Month-Day-Year)  
X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Insured\* Signature of Applicant (if other than Proposed Insured)\*

\*See page one for information regarding signatures and where to send your application.

\*If you are applying for coverage for your spouse and/or child in addition to yourself, make a copy of this application for that person.

## HOME OFFICE USE ONLY

RECEIVED	INDIVIDUAL POLICY TO BE DATED	
Name	Group Control Number	SCD
Regular Group Life	Control/Suffix	Claim/Account
Pooled Group Life	Control/Suffix	Claim/Account

## Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Attention California Residents:** For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Attention Kansas and Missouri Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Attention Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

**Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

**Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Attention New York Residents, the following statement applies only to your AD&D coverage:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

**Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

**Attention Ohio Residents:** Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

# **PREMIUM RATES FOR THE NONPARTICIPATING WHOLE LIFE 100 PLAN**

**Description:** Premium rates for your Life Insurance coverage are based upon your age (nearest birthday) when the policy takes effect and do not change thereafter.

The rates included in the tables below were appropriate for the plans at the time they were prepared. The rates are subject to change without notice. If you have any questions; want to confirm that the rates shown are the current rates; **or would like to know the rates for age 81 and up; call: 1-877-503-3448**

If your Life Insurance coverage under this policy will be at least \$10,000, Tables 1 & 3 are used.

If your Life Insurance coverage under this policy will be less than \$10,000, Tables 1, 2, & 3 are used.

**TABLE 1 — BASIC PREMIUM RATES FOR EACH \$1,000 OF LIFE INSURANCE**

Age As of Your Nearest Birthday	Annual	Semi-Annual	Quarterly	ACP/ Monthly	Age As of Your Nearest Birthday	Annual	Semi- Annual	Quarterly	ACP/ Monthly
0-1	5.12	2.64	1.34	0.44	41	20.68	10.65	5.43	1.76
2	5.04	2.60	1.32	0.43	42	21.66	11.15	5.69	1.84
3	5.23	2.69	1.37	0.44	43	22.69	11.69	5.96	1.93
4	5.43	2.80	1.43	0.46	44	23.77	12.24	6.24	2.02
5	5.64	2.90	1.48	0.48	45	24.89	12.82	6.53	2.12
6	5.85	3.01	1.54	0.50	46	26.06	13.42	6.84	2.22
7	6.07	3.13	1.59	0.52	47	27.29	14.05	7.16	2.32
8	6.30	3.24	1.65	0.54	48	28.57	14.71	7.50	2.43
9	6.54	3.37	1.72	0.56	49	29.91	15.40	7.85	2.54
10	6.80	3.50	1.79	0.58	50	31.31	16.12	8.22	2.66
11	7.07	3.64	1.86	0.60	51	32.80	16.89	8.61	2.79
12	7.34	3.78	1.93	0.62	52	34.36	17.70	9.02	2.92
13	7.61	3.92	2.00	0.65	53	36.00	18.54	9.45	3.06
14	7.88	4.06	2.07	0.67	54	37.74	19.44	9.91	3.21
15	8.16	4.20	2.14	0.69	55	39.59	20.39	10.39	3.37
16	8.45	4.35	2.22	0.72	56	41.54	21.39	10.90	3.53
17	8.75	4.51	2.30	0.74	57	43.61	22.46	11.45	3.71
18	9.04	4.66	2.37	0.77	58	45.81	23.59	12.03	3.89
19	9.34	4.81	2.45	0.79	59	48.13	24.79	12.63	4.09
20	9.64	4.96	2.53	0.82	60	50.59	26.05	13.28	4.30
21	10.01	5.16	2.63	0.85	61	53.18	27.39	13.96	4.52
22	10.33	5.32	2.71	0.88	62	55.94	28.81	14.68	4.75
23	10.66	5.49	2.80	0.91	63	58.88	30.32	15.46	5.00
24	11.02	5.68	2.89	0.94	64	61.98	31.92	16.27	5.27
25	11.40	5.87	2.99	0.97	65	65.29	33.62	17.14	5.55
26	11.79	6.07	3.09	1.00	66	68.80	35.43	18.06	5.85
27	12.19	6.28	3.20	1.04	67	72.53	37.35	19.04	6.17
28	12.60	6.49	3.31	1.07	68	76.47	39.38	20.07	6.50
29	13.02	6.71	3.42	1.11	69	80.62	41.52	21.16	6.85
30	13.46	6.93	3.53	1.14	70	85.01	43.78	22.32	7.23
31	13.90	7.16	3.65	1.18	71	89.63	46.16	23.53	7.62
32	14.37	7.40	3.77	1.22	72	94.46	48.65	24.80	8.03
33	14.87	7.66	3.90	1.26	73	99.65	51.32	26.16	8.47
34	15.40	7.93	4.04	1.31	74	105.21	54.18	27.62	8.94
35	15.99	8.23	4.20	1.36	75	111.07	57.20	29.16	9.44
36	16.62	8.56	4.36	1.41	76	117.58	60.55	30.86	9.99
37	17.31	8.91	4.54	1.47	77	124.49	64.11	32.68	10.58
38	18.07	9.31	4.74	1.54	78	131.88	67.92	34.62	11.21
39	18.88	9.72	4.96	1.60	79	139.76	71.98	36.69	11.88
40	19.75	10.17	5.18	1.68	80	148.09	76.27	38.87	12.59

TABLE 2 — Annual Premium Surcharge		TABLE 3 — Policy Fee	
If the amount of your Life Insurance coverage under this Policy will be less than \$10,000: The annual rates shown in Table 1 are added to the surcharge shown below:			
If your Policy will be:	Annual Premium Surcharge	Annual	\$ 15.00
\$ 9,000 - 9,999	\$ 1.00	Semi-Annual	8.00
8,000 - 8,999	2.00	Quarterly	4.50
7,000 - 7,999	3.00	ACP/Monthly	2.00
6,000 - 6,999	4.00		
Less than \$6,000	5.00		

**NOTE:** To determine your premium, see "HOW TO CALCULATE YOUR PREMIUM."

## HOW TO CALCULATE YOUR PREMIUM FOR THE NONPARTICIPATING WHOLE LIFE PLAN

**IF YOUR LIFE INSURANCE COVERAGE UNDER THIS POLICY WILL BE AT LEAST \$10,000**

All of the following premium modes (premium frequencies) are available to you if your policy will be at least \$10,000. Use Annual if you wish to pay your premiums annually, Semi-Annual if you wish to pay semi-annually, Quarterly if you wish to pay quarterly, or ACP/Monthly if you wish to pay monthly by Aetna's Automatic Check Plan.

**TO CALCULATE your cost estimate** use the appropriate: age; policy amount; and selected premium mode.

**EXAMPLE OUTLINED BELOW:** AGE 40 - \$20,000 Policy - Annual Premium payments.

	EXAMPLE	OUR COST ESTIMATE
1. Enter the amount of insurance requested:	\$20,000	
2. Amount of insurance requested in #1 divided by 1,000 equals:	20	
3. From Table 1, enter premium rate which corresponds with your age and selected premium mode:	19.75	
4. Multiply #2 x #3:	395.00	
5. From Table 3, enter appropriate policy fee based on the selected premium mode:	15.00	
6. Add #4 + #5. This equals your periodic premium payment for the premium mode you selected:	\$410.00	

**IF YOUR LIFE INSURANCE COVERAGE UNDER THIS POLICY WILL BE LESS THAN \$10,000**

If you wish to pay your premiums Annually, omit steps #6 + #7. If you wish to pay your premiums Semi-Annually, Quarterly, or ACP/Monthly, include steps #6 + #7.

**TO CALCULATE your cost estimate** use the appropriate age and policy amount.

**EXAMPLE OUTLINED BELOW:** AGE 40 - \$8,500 Policy - **Semi-Annual** Premium payments.

	EXAMPLE	OUR COST ESTIMATE
1. Enter the amount of Life insurance requested:	\$8,500	
2. Amount of insurance requested in #1 divided by 1,000 equals:	8.5	
3. From Table 1, enter <b>Annual</b> premium rate (regardless of premium mode selected) that corresponds with your age:	19.75	
4. From Table 2, enter <b>Annual</b> Premium Surcharge based on the amount of your policy:	2.00	
5. Add #3 + #4. <i>If you wish to pay your premiums Annually, omit steps #6 &amp; #7.</i>	21.75	
6. If your premium is to be paid Semi-Annually, enter .5150 If your premium is to be paid Quarterly, enter .2625 If your premium is to be paid ACP/Monthly, enter .085	.5150	
7. Multiply #5 x #6:	11.20	
8. Multiply #2 x (#5 for Annual Payments) or (#7 for any other payment mode)	95.20	
9. From Table 3, enter appropriate policy fee based on the selected premium mode:	8.00	
10. Add #8 + #9. This equals your periodic premium payment for the mode selected	\$103.20	



# Automatic Check Plan

## Aetna Life Insurance Company



Home Office  
Use Only

If NOT received within 15 days, and If intended as a bank change, the policy will be placed on direct billing. If intended as a transfer, the policy will remain on the current billing frequency.

Life Policy Number(s)	Insured
Life Automatic Check Plan (ACP) Number/Agency	Depositor Address
Comments	<b>NEW ACCOUNTS ONLY</b> We are able to offer these withdrawal dates. Please indicate your choice: <input type="checkbox"/> 8 <sup>TH</sup> <input type="checkbox"/> 20 <sup>TH</sup> <input type="checkbox"/> 28 <sup>TH</sup> If no date is selected we will debit your account on the 8 <sup>th</sup> . <b>EXISTING ACCOUNTS</b> The withdrawal date will not change for additions or changes.

I hereby authorize and request Aetna Life Insurance Company to initiate electronic fund transfer or check debits for premiums and other payments as indicated in the above comments section. This authority is to remain in effect until revoked by me in writing, or by Aetna Life Insurance Company if any debit is not paid upon presentation and until you actually receive such notice. I agree that you should be fully protected in honoring any such debit. The bank shall be under no obligation to furnish me with any special advice or notice in writing otherwise of such payment or charge to my account.

I understand this authorization in no way affects the terms of the policy. While premiums under the policy are being paid under this plan, such premiums will be paid on a monthly basis at the rate for such policy. In the event premiums under this plan are discontinued, premiums will be billed directly at the quarterly rate for the policy. However, if necessary, the insurer may change the premium method to direct monthly, semiannual or annual.

Authorized Signature	Date
Authorized Signature	Date



Please Attach A "Void Sample" Of Your Check, Not A Deposit Slip.

<p style="text-align: center;"><b>VOID</b> <b>SAMPLE</b> <b>CHECK</b></p>
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PLEASE DO NOT DETACH. COPY WILL BE RETURNED UPON COMPLETION OF CHANGE.

**DID YOU REMEMBER TO  
ENCLOSE A VOID SAMPLE CHECK  
SIGN THE AUTHORIZATION FORM  
INCLUDE ALL POLICY NUMBER(S)**

**THE FIRST DEBIT ON YOUR NEW ACCOUNT WILL BE EFFECTIVE \_\_\_\_\_**

To: The Bank Named on the Reverse Side

In consideration of your participation in a plan under which debits originated by and payable to the order of Aetna Life Insurance Company agrees:

To indemnify and hold you harmless from any loss you may suffer resulting from or in connection with the execution of issuance of any check or other paper whether or not genuine, purporting to be drawn by or on behalf of Aetna Life Insurance Company and payable to it pursuant to an authorization signed by one of your depositors, and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection with such loss;

In the event that any such check or other paper shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you and hold you harmless from any loss resulting from such dishonor, including reasonable costs and expenses (even though dishonor results in a forfeiture of the insurance the payment of which is sought to be collected by Aetna Life Insurance Company by such check or other paper);

To defend, at its own costs and expenses, any action which might be brought against you by any person or persons whatsoever because of your actions taken pursuant to the foregoing request or in any manner arising by reason of your participation in this agreement.

**Aetna Life Insurance Company**